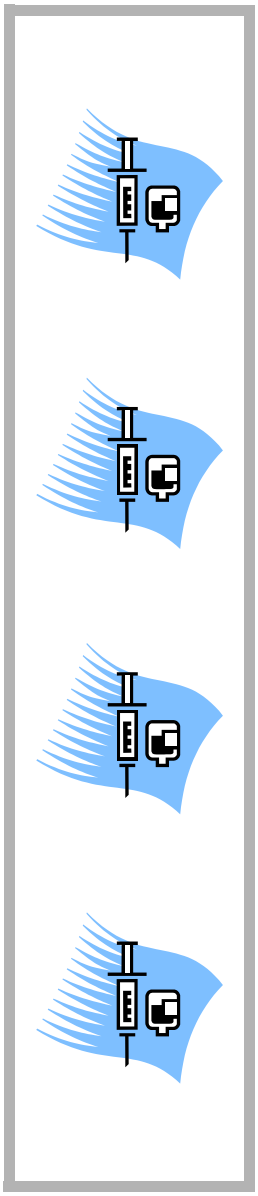

Home Infusion Therapy Services

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

This publication supersedes all previous Home Infusion Therapy Service handbooks. Published by the Montana Department of Public Health & Human Services, June 2004.

My Medicaid Provider ID Number:

MONTANA
Department of Public Health & Human Services

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Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

Provider Relations

For questions about eligibility, payments, denials, general claims questions, Medicaid or PASSPORT provider enrollment, address or phone number changes, or to request provider manuals or fee schedules:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Paper Claims

Send paper claims to:

ACS Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Prior Authorization

For prior authorization requests or for authorization for therapy requests not included in the Medicaid fee schedule:

(800) 395-7961
(406) 443-6002 (Helena)

Mail backup documentation to:

Mountain-Pacific Quality Health Foundation
3404 Cooney Drive
Helena, MT 59602

Fax backup documentation to:

(800) 294-1350
(406) 443-7014 (Helena)

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Provider's Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the G*eneral Information For Providers* manual.

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In state
(406) 443-1365 Out of state
(406) 442-0357 Fax

Send written inquiries to:

ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

Technical Services Center

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below and ask for the Medicaid Direct Deposit Manager.

(406) 444-9500

ACS EDI Gateway

For questions regarding electronic claims submissions:

(800) 987-6719 Phone
(850) 385-1705 Fax

ACS EDI Gateway Services
2324 Killearn Center Blvd.
Tallahassee, FL 32309

Key Web Sites

Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.state.mt.us	**Select *Human Services* for the following information:** • **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information. • **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • **DPHHS:** Latest news and events, Mental Health Services Plan information, program information, office locations, divisions, resources, legal information, and links to other state and federal web sites. • **Health Policy and Services Division:** Children's Health Insurance Plan (CHIP), Medicaid provider information such as manuals, newsletters, fee schedules, and enrollment information.
Provider Information Website www.mtmedicaid.org or www.dphhs.state.mt.us/hpsd/medicaid/medicaid2	• Medicaid news • Provider manuals, notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • HIPAA Update • Newsletters • Key contacts • Links to other websites and more
Medicaid Mental Health and Mental Health Services Plan www.dphhs.state.mt.us/about_us/divisions/addictive_mental_disorders/services/public_mental_health_services.htm	Mental Health Services information for Medicaid and MHSP
Health Policy and Services Division (Now Child and Adult Health Resources Division) www.dphhs.state.mt.us/hpsd	• **Medicaid:** See list under **Provider Information Website** above, and Client Information is available also • **CHIP**: Information on the Children's Health Insurance Plan • **Public Health:** Disease prevention (immunizations), health and safety, health planning, and laboratory services • **Administration:** CAHRD budgets, staff and program names and phone numbers, program statistics, and systems information. • **News:** Recent developments
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides
Washington Publishing Company www.wpc-edi.com	• EDI implementation guides • HIPAA implementation guides and other tools • EDI education

MONTANA
Department of Public Health & Human Services

Introduction

Thank you for your willingness to serve clients of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for providers of home infusion therapy services. Additional essential information for providers is contained in the separate *General Information For Providers* manual. Each provider is asked to review both manuals.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. Each manual contains a list of *Key Contacts* at the beginning. We have also included a space on the back side of the front cover to record your Medicaid Provider ID number for quick reference when calling Provider Relations.

Manual Maintenance

Accurate manuals must be kept current. Changes to manuals are provided through notices and replacement pages, which are posted on the Provider Information website (see *Key Contacts*). When replacing a page in a manual, file the old pages and notices in the back of the manual for use with claims that originated under the old policy.

Getting Questions Answered

Providers are responsible for knowing and following current laws and regulations.

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a prior authorization contractor or Provider Relations). The list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The *Introduction* chapter in the *General Information For Providers* manual also has a list of contacts for specific program policy information. Medicaid manuals, notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information website (see *Key Contacts*).

Other Department Programs

The Medicaid home infusion services in this manual are not benefits of the Mental Health Services Plan (MHSP), so the information in this manual does not apply to the MSHP program. For more information on the MHSP program, see the *Mental Health Manual* available on the Provider Information website (see *Key Contacts*).

The Medicaid home infusion services in this manual are not covered benefits of the Children's Health Insurance Plan (CHIP). Additional information regarding CHIP benefits is available by contacting BlueCross BlueShield at 1-800-447-7828 ext. 8647, or visit the CHIP website (see *Key Contacts*).

Covered Services

General Coverage Principles

This chapter provides covered services information that applies specifically to services provided by home infusion therapy providers. Like all health care services received by Medicaid clients, services rendered by these providers must also meet the general requirements listed in the *General Information For Providers* manual, *Provider Requirements* chapter. Home infusion therapy services are not covered for clients with Basic Medicaid coverage (see the *General Information For Providers* manual, *Appendix A: Covered Services*.)

Home infusion therapy is a comprehensive treatment program of pharmaceutical products and clinical support services provided to clients who are living in their home, a nursing facility, or any setting other than a hospital. A physician's authorization (prescription) for home infusion therapy allows Medicaid clients to avoid or leave the hospital care setting and receive medical care at home. Under the guidance of the client's physician, the licensed home infusion therapy provider develops and implements a treatment program to meet the particular requirements of the client.

Services within scope of practice (ARM 37.85.401)

Services are covered only when they are within the scope of the provider's license.

Licensing (ARM 37.86.1502 and 37.85.402)

Home infusion therapy providers must be licensed under Montana's health care service licensing laws. To obtain licensing requirements and procedures, contact the DPHHS Health Care Facility Licensure Bureau (see *Key Contacts*). Providers must be enrolled with Montana Medicaid as home infusion therapy providers. Providers who are also providing nursing services must enroll with Montana Medicaid as a nursing services provider.

Services for children (ARM 37.86.2201 – 2221)

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including all home infusion therapy services described in this manual. All applicable PASSPORT To Health and prior authorization requirements apply.

Non-Covered Services (ARM 37.85.207)

The Department determines which therapies are allowed as home infusion therapy services in consultation with the Department's Drug Use Review Board.

Medicaid does not cover the following services:

- Medications which can be appropriately administered orally, through intramuscular or subcutaneous injection, or through inhalation
- Drug products that are not FDA approved or whose use in the non-hospital setting present an unreasonable health risk to the client
- Services provided to Medicaid clients who are absent from the state, with the following exceptions:
  - Medical emergency
  - Required medical services are not available in Montana. Prior authorization may be required; see the *PASSPORT and Prior Authorization* chapter in this manual.
  - If the Department has determined that the general practice for clients in a particular area of Montana is to use providers in another state
  - When out-of-state medical services and all related expenses are less costly than in-state services
  - When Montana makes adoption assistance or foster care maintenance payments for a client who is a child residing in another state

Verifying coverage

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in this chapter and in the *General Information For Providers* manual, *Provider Requirements* chapter. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service.

Current fee schedules are available on the *Provider Information* web site, disk, or hardcopy. For disk or hard copy, contact Provider Relations (see *Key Contacts*).

Items Included in the Medicaid Rate

The following products and services are included in Medicaid's per diem rate for home infusion therapy services. These items may not be billed separately to Medicaid.

- All business, overhead and operational expenses
- Home infusion therapy agency staff service
  - Case management activities including coordination of treatment with other health care providers
  - Coordination of benefits, care and services

- Development of client assessment and client education materials
- Development and monitoring of nursing care plans
- Coordination of education, training and competency of field nursing staff (or sub-contracted agencies)
- Comprehensive 24 hour per day, seven days per week (24/7) delivery and pick-up services. Includes 24/7 availability of a dedicated infusion team consisting of pharmacist(s), nurse(s) and all other medical professionals responsible for clinical response, problem solving, trouble shooting, question answering and other professional duties.
- Any other services provided by the agency staff related to the client's home infusion

- Infusion therapy equipment and supplies including, but not limited to, the following:
  - Infusion therapy administration devices (e.g., durable, reusable infusion pumps and elastomeric, disposable infusion pumps)
  - Needles, gauze, sterile tubing, catheters, dressing kits, and other supplies necessary for the safe and effective administration of infusion therapy
  - Infusion access devices both short peripheral vascular devices and subcutaneous access devices, excluding peripherally inserted central lines (PIC), midlines and other centrally placed lines
  - Other applicable supply expenses
- Pharmacist professional services
  - Development and implementation of pharmaceutical care plans
  - Coordination of care with physicians, nurses, clients, client's family, other providers, and other caregivers
  - Patient/caregiver education
  - Sterile procedures, including preparation and compounding of infusion medications, clean room upkeep, vertical and horizontal laminar flow hood certification and all other biomedical procedures necessary for a safe environment
  - Initial and ongoing client assessment and clinical monitoring to include but not limited to:
    - Medication and dosage changes based upon clinical findings
    - Pharmacokinetic dosing
    - Monitoring of potential drug interactions
    - Medication profile set-up
    - Recommend appropriate laboratory monitoring
    - Review and interpretation of laboratory values and therapy progression and reporting clinical information to the client's physician and other health care providers
    - 24 hours a day, 7 days a week on call status

Coverage of Specific Services

The Montana Medicaid home infusion therapy program covers all of the drugs used in covered therapies as described in this section. All covered drugs shall be used within the FDA approval or standard of practice. Any drug outside of these areas may require literature support and Drug Use Review (DUR) Board review. For requests not found here, contact the Prior Authorization Unit (see *Key Contacts*).

The professional physician and nursing services in the provision of home infusion therapy are billed to Medicaid by those providers, not the home infusion therapy provider.

The following table lists home infusion therapy covered services, criteria, and whether the service requires prior authorization (see the *PASSPORT and Prior Authorization* chapter in this manual). All covered drugs, solutions, or durable medical equipment (DME) supplies are billed separately by the pharmacy or DME provider unless otherwise stated.

Home Infusion Therapy Covered Services

Service	Criteria	PA
Alpha 1 proteinase inhibitor	Treatment of congenital alpha-1 antitrypsin deficiency. Infusion pump always required.	Y
Anticoagulant therapy	Continuous anticoagulant infusion therapy (e.g. heparin). Low molecular weight heparin is not covered as an infusion therapy.	Y
Antiemetic therapy	Intermittent or continuous IV infusion of antiemetic therapy that prevents or alleviates irretractable nausea and vomiting.	Y
Anti-infective therapy	Intravenous administration of antibacterial, antiviral or antifungal medications appropriately constituted and admixed with an IV solution. Treatment normally requires an infusion pump, especially if more than one anti-infective is being infused or if prescribed for a pediatric client.	Y
Anti-spasmodic therapy	Infusion of anti-spasmotic agents, which prevents or alleviates muscle spasms. Typically this requires an infusion pump.	Y
Anti-tumor necrosis factor	Infusion of anti-tumor necrosis factor-alpha for an FDA approved use. Typically this therapy requires and infusion pump.	Y
Catheter care	Occasionally a client will require care of a catheter other than simple flushing supplies, which the client shall complete independently. Covered catheter care shall include catheter declotting and catheter repair supply kit. Simple maintenance flushing of a catheter shall not be routinely covered under a per diem procedure; extenuating circumstances may be negotiated with the prior authorization unit.	N

Home Infusion Therapy Covered Services (continued)

Service	Criteria	PA
Chelation (desferal therapy)	Therapy that is used parenterally to reduce the iron stored in the body in clients with hemochromatosis, acute iron poisoning, or abnormal storage of iron due to multiple blood transfusions.	Y

Chemotherapy	• Antineoplastic/cytotoxic agents - Any agent that destroys or prevents the development, growth or proliferation of malignant cells. This group of compounds is most often used in cancer chemotherapy.
	• Other drugs used for the treatment of a cancer diagnosis must meet one of the following criteria in order to be presented for review by the DUR Board:
	  • The drug must be FDA approved for the diagnosis
	  • The drug must be standard of practice for treatment of the diagnosis
	• Parenteral administration of antineoplastic medications appropriately reconstituted and possibly admixed with an IV solution and requiring cytotoxic precautions in preparation, administration, and disposal of supplies.
	• Often requires an infusion pump or specialized delivery system
	• Continuous administration is defined as that which occurs without interruption over a period of 24 hours or more. Intermittent administration is for chemotherapy administered for a period of less than 24 hours.
		Y

Corticosteroid therapy	Anti-inflammatory treatment with various steroid hormones used to control acute or chronic symptoms such as those of multiple sclerosis.	N
Epoprostenol therapy	Intravenous administration of epoprostenol therapy for the treatment of pulmonary hypertension. Always requires an infusion pump.	N
Hydration	• Parenteral administration of combinations of dextrose or its derivative and/or saline solution, or lactated ringer's solution and possibly electrolytes to correct or prevent dehydration. • Treatment may require an infusion pump.	N
Immunomodulating agents	Treatment involving the modification of the functioning of the immune system by the action of a substance that increases or reduces the ability to produce antibodies	Y
Inotropic agents	• Intravenous administration of sympathomimetic/inotropic (e.g. dobutamine) medications to improve cardiac performance • Therapy requires the use of an infusion pump due to the potential for adverse cardiac effects	Y
Pain management	• Intravenous or subcutaneous administration of narcotic analgesics admixed in IV solutions with individualized dosage units and delivery systems per client specific needs • Always requires an infusion pump • The fee applies regardless of the method of delivery or the number of cassettes used per week	Y
Tocolytic therapy (preterm labor prevention)	Subcutaneous or intravenous administration of tocolytic drugs for prevention and control of preterm uterine contractions	N

Home Infusion Therapy Covered Services (continued)

Service	Criteria	PA

Total parenteral nutrition (TPN)	• Providing complete nutritional requirements intravenously by carefully controlling the composition of fluid given with respect to total calories derived from protein hydrolysate and dextrose, as well as fats, electrolytes, minerals and vitamins.
	• Any IV solution including amino acids and one or more non-protein sources of calories plus electrolytes, minerals, vitamins, insulin, or other medications for a client who is unable to take or absorb food orally. Always requires an infusion pump. The basic parenteral nutrition solution containing standard TPN elements as defined below are included in the per diem rate:
	  • Non-specialty amino acids
	  • Concentrated dextrose solutions
	  • Sterile water
	  • Electrolytes (e.g. CaCl2, KCL, KPO4, MgSo4, NaAc, NaCl, NaPO4)
	  • Standard multi-trace element solutions
	  • Standard multivitamin solutions
	  • Insulin
	• NOT included in the TPN per diem are the following items to be coded separately:
	  • Specialty amino acids for renal failure; hepatic failure; high stress conditions; with concentrations of 15% or more when medically necessary for fluid restricted clients
	  • Lipids
	  • Added trace elements not from a standard multi-trace solution
	  • Added vitamins not from a standard multivitamin solution
	  • Products serving non-nutritional purposes (e.g. other drugs, heparin, H2 antagonists, etc.)
		Y

Other infusion therapies	Anticipating that new infusion therapies will be developed or that a current therapy has been overlooked, the Department will consider authorization of other therapies on an individual basis. These special requests may require literature documentation, peer review, and review by the DUR Care Board. In addition, the request will require cost information for setting a per diem rate. Contact the Prior Authorization Unit (see *Key Contacts*)	Y

MONTANA
Department of Public Health & Human Services

PASSPORT and Prior Authorization

What Are PASSPORT, Prior Authorization and a Restricted Card? (ARM 37.86.5101 - 5120)

PASSPORT To Health, prior authorization (PA), and the Restricted Card Program are three examples of the Department's efforts to ensure the appropriate use of Medicaid services. In most cases, providers need approval before services are provided to a particular client. PASSPORT approval and prior authorization are different, and some services may require both. A different code is issued for each type of approval and must be included on the claim form (see the *Submitting A Claim* chapter in this manual).

- ***PASSPORT To Health Managed Care Program*** is Montana Medicaid's Primary Care Case Management (PCCM) Program and has been very successful since implementation in 1993. Under PASSPORT, Medicaid clients choose one primary care provider and develop an ongoing relationship that provides a "medical home." With some exceptions, all services to PASSPORT clients must be provided or approved by the PASSPORT provider. The PASSPORT mission is to manage the delivery of health care to Montana Medicaid clients in order to improve or maintain access and quality while minimizing use of health care resources. Approximately 68% of the Medicaid population is enrolled in PASSPORT. Most Montana Medicaid clients must participate in PASSPORT with only a few exceptions. See the *General Information For Providers* manual for more information on these clients. Any Montana Medicaid provider may be a PASSPORT provider if primary care is within his or her scope of practice. The PASSPORT Program saves the Medicaid Program approximately $20 million each year. These savings allow improved benefits elsewhere in the Medicaid Program.
- ***Prior authorization*** refers to a list of services. If a service requires prior authorization, the requirement exists for all Medicaid clients. See *Prior Authorization* later in this chapter for instructions on getting services prior authorized.
- A ***restricted card*** is issued to a very small number of Medicaid clients. Because of issues about the appropriate use of services, the client must use a specific physician and/or pharmacy. For more information, see the *General Information For Providers* manual, *Client Eligibility and Responsibilities*.

Medicaid does not pay for services when prior authorization, PASSPORT, or restricted card requirements are not met.

Most home infusion therapy services do not require PASSPORT provider approval. However, when home infusion therapy services are provided by a registered nurse employed by a home infusion therapy agency, PASSPORT provider approval is required. Some services also require prior authorization regardless of whether the client is a PASSPORT enrollee. PASSPORT approval requirements are described below. In the few cases where an eligibility verification shows that a client is restricted to a certain provider or pharmacy, all providers must follow the restrictions on the eligibility documentation.

How to Identify Clients on PASSPORT

Client eligibility verification will list the client's PASSPORT provider name and phone number. The card will also indicate whether the client has full or basic coverage. Instructions for checking client eligibility are in the *General Information For Providers* manual, *Client Eligibility and Responsibilities* chapter.

How to Obtain PASSPORT Approval

When providing a covered medical service that requires PASSPORT approval, check the client's eligibility information for the client's primary care provider. Contact the primary care provider and request approval before providing services. The PASSPORT approval number must be recorded on the claim (see the *Submitting a Claim* chapter in this manual).

Prior Authorization

Many services require prior authorization (PA) **before** providing them. These requirements have been established after consultation with the Department's Drug Use Review (DUR) Board. Criteria listed for each therapy are derived from reviews completed by the University of Montana's School of Pharmacy and approved by the DUR Board. PA requests are reviewed for medical necessity. When seeking PA, keep in mind the following:

- Always refer to the current Medicaid fee schedule to verify if PA is required for specific services. The following table *Prior Authorization Criteria for Specific Services* lists services that require PA and the corresponding criteria.
- Remember to bill for only the number of units that were prior authorized.
- To request prior authorization, providers must submit the information requested on the *Mountain-Pacific Quality Health Foundation Request for Drug Prior Authorization* form to the Prior Authorization Unit. This form is in *Appendix A: Form*s.
- Physicians, home infusion therapy providers, or pharmacy providers may submit PA requests by mail, telephone, or fax to the PA unit (see *Key Contacts*).

- Requests are reviewed and decisions made immediately in most cases. Decisions on requests with special circumstances that require further peer review are made within 24 hours. Requests received after the PA Unit's regular working hours of 8 a.m. to 5 p.m. Monday through Friday, or on weekends or holidays are considered received at the start of the next working day.
- If the weekend/holiday request is for an emergency situation, providers may supply therapies shown on the Medicaid fee schedule and payment will be authorized up to a maximum of three (3) days. Medicaid may routinely audit these emergency authorizations for validity and appropriateness. Therapies in the "other infusion therapies" category will not be authorized on an emergency basis. Provider who are billing point-of-sale should refer to the *Prescription Drug Program* manual when billing for emergency therapies.
- The prior authorization unit notifies the provider when prior authorization has been granted or denied. Upon approval, providers will receive a prior authorization number that must be recorded on the claim.

Prior Authorization for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, he or she should present the provider with an FA-455 (eligibility determination letter). Providers may choose whether or not to accept retroactive eligibility (see the *General Information For Providers* manual, *Client Eligibility* chapter). All prior authorization requirements must be met to receive Medicaid payment. When requesting PA, attach a copy of the FA-455 to the PA request. It is the client's responsibility to ensure his or her caseworker prepares an FA-455 for each provider who participates in the client's health care during this retroactive period. See the *Billing Procedures* chapter in the manual for retroactive eligibility billing requirements.

PA Criteria for Specific Services

Service	Criteria
Alpha 1 proteinase inhibitor (Prolastin)	Alpha 1 antitrypsin deficiency must be documented via laboratory information.
Anticoagulant therapy	• Client must not be a candidate for low molecular weight heparin therapy, either due to therapy failure, client status or diagnosis. • A plan for oral therapy must be submitted, if appropriate.
Antiemetic therapy	Client must have failed all other forms of antiemetic therapy including oral, rectal and intermittent subcutenous injection.
Anti-infective therapy (antibiotics/antifungals/antivirals)	• IV Antibiotic therapy for two weeks or less will be authorized upon request. • IV Antibiotic therapy for more than two weeks will be considered on an individual basis depending on diagnosis and client condition. • IV Antibiotic therapy using IV fluroquinolones or metronidazole has not been found to have any therapeutic advantage over oral therapies and also requires PA.
Antispasmodic therapy	Client must have failed oral forms of antispasmotic therapy.
Anti-tumor necrosis factor (Remicaid)	The indication must be FDA approved or have good published studies supporting the indication for use.
Chemotherapy	• The indication must be FDA approved or have good published studies supporting the indication for use. • The drugs must not be considered vesicants, which cause severe local necrosis (tissue damage) and should not be given in the home; extravasation (leaking out of the vein into local tissue) needs to be recognized and treated immediately. Too dangerous a side-effect for the home administration.
Chelation (desferal therapy)	Documentation of hemochromatosis, acute iron poisoning, or abnormal storage of iron due to multiple blood transfusions.

Immunomodulating agents	• Prior authorization is required for the use of any intravenous immunoglobulin (IVIG) products.
	• Must be a diagnosis of one of the following:
	  • Primary immunodeficiency disorders with a history of recurrent infections
	  • Idiopathic thrombocytopenic purpura (ITP):
	  • Children with newly diagnosed ITP who are not a risk for serious hemorrhage
	  • Chronic ITP
	  • Adult-onset ITP in those clients who do not respond to initial corticosteroid therapy
	  • Allogeneic bone marrow transplantation
	  • Symptomatic pediatric HIV infection and CD4 lymphocyte count greater than 200
	  • Chronic lymphocytic leukemia with a history of at least one serious bacterial infection
	  • Guillain-Barre syndrome
	  • Kawasaki syndrome

Inotropic agents (dobutamine therapy)	Must be a diagnosis of chronic refractory CHF which meets the following criteria: • Client shows no clinical improvement (FC-III or FC-IV) despite treatment with maximum or near-maximum tolerated doses of standard oral therapy for CHF (unless allergic or intolerant) • Client is clinically stable on the dosage to be administered at home prior to discharge from the hospital • Client demonstrates either an improvement in FC from IV to III, or an improvement in symptoms (less dyspnea, improved diuresis, improved renal function, and/or reduction in weight) and hemodynamic parameters (at least 20 percent increase in cardiac output, decreased pulmonary artery pressure, and/or a decrease in pulmonary capillary wedge pressure, measured invasively within six months prior to the initiation of therapy) • Client demonstrates a clinical dependence on the inotrope as evidenced by deterioration in clinical status when the drug is tapered or discontinued.

PA Criteria for Specific Services (continued)

Service	Criteria
Pain management	• All other forms of pain therapy must have failed, including but not limited to oral, sublingual, rectal, topical • The client must not be a candidate for, or client of Hospice Services

Total parenteral nutrition (TPN)	• Recertification is required at 3 months, 9 months, and 24 months after the initiation of therapy. After two years, authorization will be determined on a case-by-case basis. If, at any time, there is a break in service to the client of two consecutive months, the entire review process will begin again.
	• clients must meet the following criteria:
	  • A client must be unable to meet nutrient requirements via the GI tract safely and adequately. Adequate nutrition cannot be completely possible by dietary adjustment, oral supplements, or tube enteral nutrition.
	  • The client's GI tract must be severely diseased, preventing absorption of adequate nutrients to maintain weight and strength consistent with the client's overall status. TPN must be necessary to sustain the client's life. Examples of conditions and/or functional impairments that may qualify for coverage include, but are not limited to:
	  • Massive small bowel resection
	  • Crohn's disease
	  • Sprue
	  • Short bowel syndrome
	  • Radiation enteritis
	  • Malabsorption documented by a physician
	  • GI tract mechanical obstruction
	  • A total caloric intake of 20-35 kcal/kg (of ideal body weight)/day constitutes nutritional dependence.
	  • Peripheral parenteral nutrition may be used in selected clients to provide partial or total nutrition support for up to two weeks in clients who cannot ingest or absorb adequate oral or enteral tube-delivered nutrients, or when central-vein parenteral nutrition is not feasible.
	  • The client should not have pulmonary edema, congestive heart failure (New York Heart Association Functional Class 3 or 4), or any other medical condition that would increase the risk of home administration.
	  • Central-vein parenteral nutrition support, including support via a PICC line, is provided when parenteral feeding is indicated for longer than two weeks, peripheral venous access is limited, or nutrient needs are large or fluid restriction is required.

Other therapies	Anticipating that new infusion therapies will be developed or that a current therapy has been overlooked, the Department will consider authorization of other therapies on an individual basis. These special requests may require literature documentation, peer review, as well as review by the DUR Board. In addition, the request will require cost information for setting a per diem rate. Contact the Prior Authorization Unit (see *Key Contacts*).

Coordination of Benefits

When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers should bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to Billing Third Party First* in this chapter). Medicare is processed differently than other sources of coverage.

Identifying Additional Coverage

The client's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (see the *General Information For Providers* manual, *Client Eligibility and Responsibilities*). If a client has Medicare, the Medicare ID number is provided. If a client has additional coverage, the carrier is shown. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' Compensation Insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long term care insurance

*These third party payers (and others) may **not** be listed on the client's eligibility verification.

Providers should use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Client Has Medicare

Medicare claims are processed and paid differently than other non-Medicaid claims. The other sources of coverage are called third party liability or TPL, but Medicare is not.

Medicare Part B crossover claims

Home infusion therapy services may be covered under Medicare Part B. The Department has an agreement with the Medicare Part B carriers for Montana (BlueCross BlueShield of Montana and the Durable Medical Equipment Regional Carrier [DMERC]) under which the carriers provide the Department with a magnetic tape of CMS-1500 claims for clients who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically, and must have their Medicare provider number on file with Medicaid.

To avoid confusion and paperwork, submit Medicare Part B crossover claims to Medicaid only when necessary.

When clients have both Medicare and Medicaid covered claims, and have made arrangements with both Medicare and Medicaid, Part B services need not be submitted to Medicaid. When a crossover claim is submitted only to Medicare, Medicare will process the claim, submit it to Medicaid, and send the provider an Explanation of Medicare Benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see the *Billing Procedures* chapter in this manual).

Providers should submit Medicare crossover claims to Medicaid only when:

- The referral to Medicaid statement is missing. In this case, submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- The referral to Medicaid statement is present, but you do not hear from Medicaid within 45 days of receiving the Medicare EOMB. Submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- Medicare denies the claim, you may submit the claim to Medicaid with the EOMB and denial explanation (as long as the claim has not automatically crossed over from Medicare).

All Part B Crossover claims submitted to Medicaid before the 45-day Medicare response time will be returned to the provider.

When submitting electronic claims with paper attachments, see the *Billing Electronically with Paper Attachments* section of the *Submitting a Claim* chapter in this manual.

When submitting a Medicare crossover claim to Medicaid, use Medicaid billing instructions and codes; they may not be the same as Medicare's.

When submitting a claim with the Medicare EOMB, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must also include the Medicaid provider number and Medicaid client ID number. It is the provider's responsibility to follow-up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see the *Billing Procedures* chapter in this manual).

When a Client Has TPL (ARM 37.85.407)

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability or TPL. In most cases, providers must bill other insurance carriers before billing Medicaid.

Providers are required to notify their clients that any funds the client receives from third party payers (when the services were billed to Medicaid) must be turned over to the Department. The following words printed on the client's statement will fulfill this obligation, "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid."

Exceptions to billing third party first

In a few cases, providers may bill Medicaid first:

- When a Medicaid client is also covered by Indian Health Services (IHS) or Crime Victim's Compensation, providers must bill Medicaid first. These are not considered a third party liability.
- When a client has Medicaid eligibility and MHSP eligibility for the same month, Medicaid must be billed first.
- Some prenatal and pediatric codes can be billed directly to Medicaid. In these cases, Medicaid will "pay and chase" or recover payment itself from the third party payer.

Codes That May be Billed to Medicaid First

ICD-9-CM Prenatal Codes	ICD-9-CM Preventive Pediatric Codes
V22.0	V01.0 – V01.9
V22.1	V02.0 – V02.9
V23.0 – V23.9	V03.0 – V06.9
V28.0 – V28.9	V07.0 – V07.9
640.0 – 648.9*	V20.0 – V20.2
651.0 – 658.9*	V70.0
671.0 – 671.9	V72.0 – V72.3
673.0 – 673.8	V73.0 – V75.9
675.0 – 676.9	V77.0 – V77.7
	V78.1 – V78.3
	V79.2 – V79.3
	V79.8
	V82.3 – V82.4

* In these two ranges, the code only qualifies for the exemption if the fifth digit is a 3 (e.g. 648.93).

- If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim. Instead, notify the Department of the potential third party by sending the claim and notification directly to the Third Party Liability Unit (see *Key Contacts*).

Requesting an exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information should be sent directly to the ACS Third Party Liability Unit (see *Key Contacts*).

- When a provider is unable to obtain a valid assignment of benefits, the provider should submit the claim with documentation that the provider attempted to obtain assignment and certification that the attempt was unsuccessful.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
  - The third party carrier has been billed, and 30 days or more have passed since the date of service.
  - The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.
- If another insurance has been billed, and 90 days have passed with no response, submit the claim with a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.

When the third party pays or denies a service

If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid when submitting the claim to Medicaid for processing.
- Allows the claim, and the allowed amount went toward client's deductible, include the insurance Explanation of Benefits (EOB) when billing Medicaid.
- Denies the claim, submit the claim and a copy of the denial (including the reason explanation) to Medicaid.
- Denies a line on the claim, bill the denied line on a separate claim and submit to Medicaid. Include the explanation of benefits (EOB) from

the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

When the third party does not respond

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Submit the claim and a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company).
- Include the date the claim was submitted to the insurance company.
- Send this information to the ACS Third Party Liability Unit (see *Key Contacts*).

Billing Procedures

Claim Forms

Services provided by the health care professionals covered in this manual must be billed either electronically or on a CMS-1500 claim form (formerly known as the HCFA-1500). CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within the latest of:

- Twelve months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- For claims involving Medicare or TPL, if the twelve month time limit has passed, providers must submit clean claims to Medicaid within:
  - ***Medicare Crossover Claims:*** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
  - ***Claims involving other third party payers (excluding Medicare):*** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All problems with claims must be resolved within this 12 month period.

Tips to avoid timely filing denials

- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual).
- If a claim submitted to Medicaid does not appear on the remittance advice within 30 days, contact Provider Relations for claim status (see *Key Contacts*).
- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid (see the *Coordination of Benefits* chapter in this manual for more information).

- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the *Coordination of Benefits* chapter in this manual.

When To Bill Medicaid Clients (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid clients for services covered under Medicaid. The main exception is that providers may collect cost sharing from clients.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a third-party payer does not respond.
- When a client fails to arrive for a scheduled appointment. Medicaid may not be billed for no-show appointments.
- When services are free to the client. Medicaid may not be billed for those services either.

Under certain circumstances, providers may need a signed agreement in order to bill a Medicaid client (see the following table).

If a provider bills Medicaid and the claim is denied because the client is not eligible, the provider may bill the client directly.

When to Bill a Medicaid Client (ARM 37.85.406)

	• Client Is Medicaid Enrolled • Provider Accepts Client as a Medicaid Client	• Client Is Medicaid Enrolled • Provider Does Not Accept Client as a Medicaid Client	• Client Is Not Medicaid Enrolled
Service is covered by Medicaid	Provider can bill client **only** for cost sharing	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client
Service is not covered by Medicaid	Provider can bill client only if custom agreement has been made between client and provider before providing the service	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client

Routine Agreement: This may be a routine agreement between the provider and client which states that the client is not accepted as a Medicaid client, and the he or she must pay for the services received.

Custom Agreement: This agreement lists the service the client is receiving and states that the service is not covered by Medicaid and that the client will pay for it.

Client Cost Sharing (ARM 37.85.204)

Cost sharing fees are a set dollar amount per visit, and they are based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. Cost sharing for home infusion therapy services is $5.00 per visit (or span). When providing therapy over a span of several days, cost sharing is taken once for the time span for each different therapy provided. For example, if a client is receiving pain management (S9326) and anti-infective therapy (S9500) once a day for 15 days, a $10.00 cost sharing fee will be charged for these services. There is no cost sharing cap. Do not show cost sharing as a credit on the claim; it is automatically deducted during claims processing and is shown on the remittance advice. Cost sharing for the following services is shown below.

The following clients are exempt from cost sharing:

- Clients under 21 years of age
- Pregnant women (until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed)
- Inpatients in a hospital, skilled nursing facility, intermediate care facility or other medical institution if the individual is required to spend all but their personal needs allowance on the cost of care.
- Medicaid clients who also have Medicare or another insurance are exempt from cost sharing only when the service is allowed by Medicare or paid by the other insurance, and Medicaid is the secondary payer.

A provider cannot deny services to a Medicaid client because the client cannot pay cost sharing fees at the time services are rendered. However, the client's inability to pay cost sharing fees when services are rendered does not lessen the client's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid clients, that same policy may be used for Medicaid clients. A provider may sever the relationship with a client who has unpaid cost sharing obligation, as long as a consistent policy is followed with Medicaid and non-Medicaid clients. Once the relationship is severed, with prior notice to the client either verbally or in writing, the provider may refuse to serve the client.

When Clients Have Other Insurance

If a Medicaid client is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the client's health care, see the *Coordination of Benefits* chapter in this manual.

Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (Eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the service(s) before billing Medicaid for the service(s).

For more information on retroactive eligibility, see the *General Information For Providers* manual, *Client Eligibility and Responsibilities* chapter.

Usual and Customary Charge (ARM 37.85.406)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service.

Coding

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the table of *Coding Resources* on the following page. The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current CPT-4, HCPCS Level II, and ICD-9-CM coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use the correct "units" measurement on the claim. See *Per Diem Rates and Units* in this chapter.

Coding Resources

Please note that the Department does not endorse the products of any particular publisher.

Resource	Description	Contact
ICD-9-CM	• ICD-9-CM diagnosis and procedure codes definitions • Updated each October.	Available through various publishers and bookstores
CPT-4	• CPT-4 codes and definitions • Updated each January	American Medical Association (800) 621-8335 www.amapress.com or Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
HCPCS Level II	• HCPCS Level II codes and definitions • Updated each January and throughout the year	Available through various publishers and bookstores or from CMS at www.hcfa.gov/medicare/hcpcs.htm
CPT Assistant	A newsletter on CPT-4 coding issues	American Medical Association (800) 621-8335 www.amapress.com
Miscellaneous resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT-4 or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service.	National Technical Information Service (800) 363-2068 (703) 605-6060 www.ntis.gov/product/correct-coding.htm

Using the Medicaid Fee Schedule

When billing Medicaid, it is important to use the Department's fee schedule for your provider type in conjunction with the detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. In addition to covered services and payment rates, fee schedules often contain helpful information such as appropriate modifiers and prior authorization indicators. Department fee schedules are updated each January and July. Current fee schedules are available on the *Provider Information* web site (see *Key Contacts*). For disk or hardcopy, contact Provider Relations (see *Key Contacts*).

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT-4, HCPCS Level II, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- The Medicaid claims processing system recognizes only two pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- Modifiers SH and SJ must be used when billing for multiple concurrent therapies. The per diem rate of multiple concurrent therapies are discounted 20% off the per diem rate for the second concurrently administered therapy and 25% for the third or more concurrently administered therapy. The discount(s) may be applied to the lower cost therapy.
  - Use modifier **SH** for the second concurrently administered therapy.
  - Use **SJ** for the third or more concurrently administered therapy.

Per Diem Rate and Units

The term "per diem" represents each day that a client is provided access to a prescribed therapy, beginning the day therapy is initiated and ending with the day the therapy is permanently discontinued. Each day represents a 24 hour period. The expected course and duration of therapy is determined by the plan of care as prescribed by the ordering physician with pharmacist evaluation.

The number of units billed is the number of days in which the therapy was actually provided. When a prescription is written in a number of doses, per diem units are calculated by dividing the total prescribed doses by the daily dosing schedule rounded up to the nearest day. For example, a home infusion therapy provider has a prescription for 13 doses of an antibiotic to be given four times a day to a client:

13 doses / by 4 times a day = 3.25 rounded up to the nearest day = 4

The provider will bill for 4 units of therapy as shown:

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 04	15	04	04	18	04	12	0	S9504		1	700 00	4				

When dosing is given less frequently than every 24 hours (e.g. 48 or 72 hours), the per diem unit count starts with dose 1 and ends with the last dose counting only days in which the therapy was provided. For example, if a client receives IV antibiotics every 48 hours for two weeks, the provider can bill for 7 units (or days) of therapy as shown below. Note that the number of units billed must not exceed the number of days in the billing span.

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03	01	04	03	14	04	12	0	S9500		1	1,050 00	7				

Billing Tips for Specific Providers

Home health agency

Nursing services provided by a Medicaid-enrolled home health agency must be billed by that agency and not by the home infusion therapy provider. Nursing services are billed in accordance with home health program procedures (see the *Home Health Services* manual).

Home infusion therapy agency

When nursing services are provided by registered nurses employed by the home infusion therapy agency, the provider must enroll as a private duty nursing provider and bill under that Medicaid provider number. Agencies must use the following codes for billing Medicaid for home infusion therapy services provided by a registered nurse employed by the agency. PASSPORT provider approval is required for these services. For more billing information for this provider type, see the *Private Duty Nursing* section of the *EPSDT* manual.

Professional nursing services are not separately billable when home infusion therapy is provided in a nursing facility.

Therapy Agency Home Infusion Codes	
99601	Home infusion - specialty drug administration, per visit up to 2 hours
99602	Home infusion, specialty drug administration, each additional hour

Providers are responsible for maintaining documentation to support all nursing services billed. The Quality Assurance Division periodical verifies billed nursing services.

Pharmacy providers

All pharmaceuticals associated with the delivery of an infusion therapy are billed through the pharmacy program using the individual product NDC. Pharmacy providers that are also Medicaid-enrolled home infusion therapy services providers, should refer to the *Prescription Drug Program* manual for billing instructions.

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Client number not on file, or client was not eligible on date of service	Before providing services to the client: • View the client's eligibility information at each visit; Medicaid eligibility may change monthly. • Verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.
Procedure requires PASSPORT provider approval – No PASSPORT approval number on claim	A PASSPORT provider approval number must be on the claim form when such approval is required. See the *PASSPORT and Prior Authorization* chapter in this manual.
Duplicate claim	• Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see *Remittance Advices and Adjustments* in this manual). • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Prior authorization number is missing	• Prior authorization (PA) is required for certain services, and the PA number must be on the claim form (see the *PASSPORT and Prior Authorization* chapter in this manual).

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
TPL on file and no credit amount on claim	• If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See *Coordination of Benefits* in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim.
Claim past 365-day filing limit	• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in *Key Contacts*.
Missing Medicare EOMB	All Medicare crossover claims on CMS-1500 forms must have an EOMB attached.
Provider is not eligible during dates of services, or provider number terminated	• Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Type of service/procedure is not allowed for provider type	• Provider is not allowed to perform the service. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.

Submitting a Claim

Electronic Claims

Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ***ACS field software WINASAP 2003.*** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- ***ACS clearinghouse.*** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway. For more information on using the ACS clearinghouse, contact ACS EDI Gateway (see *Key Contacts*).
- ***Clearinghouse.*** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

Billing Electronically with Paper Attachments

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

9999999	-	**888888888**	-	**11182003**
Medicaid Provider ID		Client ID Number		Date of Service (mmddyyyy)

The supporting documentation must be submitted with a paperwork attachment cover sheet (located on the Provider Information website and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

Paper Claims

The services described in this manual are billed on CMS-1500 claim forms. Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the *Billing Procedure*s chapter in this manual).

Claims are completed differently for the different types of coverage a client has. This chapter includes instructions and a sample claim for the following scenarios:

- Client has Medicaid coverage only
- Client has Medicaid and third party liability coverage

When completing a claim, remember the following:

- Required fields are indicated by "*".
- Fields that are required if the information is applicable to the situation or client are indicated by "**".
- Field 24h, *EPSDT/family planning*, is used to override copayment and PASSPORT authorization requirements for certain clients or services. The following are accepted codes:

EPSDT/Family Planning Overrides		
Code	**Client/Service**	**Purpose**
1	EPSDT	Overrides some benefit limits for client under age 21
2	Family planning	Overrides the Medicaid cost sharing and PASSPORT authorization on the line
3	EPSDT and family planning	Overrides Medicaid cost sharing and PASSPORT authorization for persons under the age of 21
4	Pregnancy (any service provided to a pregnant woman)	Overrides Medicaid cost sharing on the claim
6	Nursing facility client	Overrides the Medicare edit for oxygen services on the **line**

Unless otherwise stated, all paper claims are mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

All Medicaid claims must be submitted on Department approved claim forms. CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Client Has Medicaid Coverage Only

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a	Insured's ID number	Leave this field blank for Medicaid only claims.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
5	Patient's address	Client's address.
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11d*	Is there another health benefit plan?	Enter "No". If "Yes", follow claim instructions for appropriate coverage later in this chapter.
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format. This field is optional for Medicaid only claims.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format. This field is optional for Medicaid only claims.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Medicaid only claims.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (12).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT-4/HCPCS modifier. Medicaid allows up to three modifiers per procedure code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your usual and customary charges for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units).
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the *EPSDT/Family Planning Overrides* table in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave blank or enter $0.00. Do not report any client copay or Medicaid payment amounts on this form.
30*	Balance due	Enter the balance due as recorded in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which is either hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the provider or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid Coverage Only

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Rhoads, Rocky L.

3. PATIENT'S BIRTH DATE MM DD YY: 04 28 33 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Anystreet #1

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-5555

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Harold Hunter, MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 9989999

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 730.27 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 999999

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 01 04	03 25 04	12	0	S9502		1	3,750 00	25				
2 03 01 04	03 25 04	12	0	S9501	SH	1	3,750 00	25				
3												
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 99-9999999 [ ] [X]

26. PATIENT'S ACCOUNT NO.: 99999

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 7,500 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 7,500 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Betty Biller 04/01/04

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Home IV Services
P.O. Box 999
Anytown, MT 59999

PIN# 0000099999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid and Third Party Liability Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's ID number for the primary carrier.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11	Insured's policy group	Leave this field blank, or enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (12).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your usual and customary charge for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units).
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the *EPSDT/Family Planning Overrides* table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the other insurance. Do not include any adjustment amounts or coinsurance.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the provider or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid and Third Party Liability Coverage

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Breeze, Summer

3. PATIENT'S BIRTH DATE MM DD YY: 08 31 54 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 4321 Anystreet

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE:

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406)999-9999

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE: 9999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Smith, Steven R. MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 9999999

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 787.01
2. 191.9
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 99999

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 04 01 04	04 30 04	12	0	S9351		1	4,500 00	30				
2 04 01 04	04 30 04	12	0	S9327		1	3,750 00	30				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 8,250 00

29. AMOUNT PAID $ 3,250 00

30. BALANCE DUE $ 5,000 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Betty Biller 05/01/04

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Home IV Services
P.O. Box 999
Anytown, MT 59999

PIN# 999999 GRP# (406) 999-9999

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

CMS-1500 Agreement

Your signature on the CMS-1500 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Claim Inquiries

Claim inquiries can be obtained electronically through ANSI ASC X12N 276/277 transactions or by contacting Provider Relations. See the *Companion Guides* located on the ACS EDI Gateway website for more information on electronic transactions (see *Key Contacts*). Providers may contact Provider Relations for questions regarding payments, denials, and other claim questions (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A*. Complete the top portion of the form with the provider's name and address.

Provider Relations will respond to the inquiry within 7 to 10 days. The response includes the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

Avoiding Claim Errors

Claims are often denied or even returned to the provider before they can be processed. To avoid denials and returns, double check each claim form to confirm the following items are accurate. For more information on returned and denied claims, see the *Billing Procedures* chapter in this manual.

Common Claim Errors

Claim Error	Prevention
Required field is blank	Check the claim instructions earlier in this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.
Client ID number missing or invalid	This is a required field (field 10d); verify that the client's Medicaid ID number is listed as it appears on the client's eligibility information.
Client name missing	This is a required field (field 2); check that it is correct.
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Referring or PASSPORT provider name and ID number missing	When a provider refers a client to another provider, include the referring provider's name and ID number or PASSPORT number (see *PASSPORT and Prior Authorization* in this manual).
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be on the claim (see *PASSPORT and Prior Authorization* in this manual).
Not enough information regarding other coverage	Fields 1a and 11d are required fields when a client has other coverage (refer to the examples earlier in this chapter).

Common Claim Errors (continued)

Claim Error	Prevention
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Medicare EOMB not attached	When Medicare is involved in payment on a claim, the Medicare EOMB must be submitted with the claim or it will be denied.

MONTANA
Department of Public Health & Human Services

Remittance Advices and Adjustments

The Remittance Advice

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* in this chapter). Each line of the RA represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

Electronic RA

Providers may receive the RA electronically as an ANSI ASC X12N 835 transaction, or through the Internet on the Montana Eligibility and Payment System (MEPS). For more information on X12N 835 transactions, see the Companion Guides available on the ACS EDI Gateway website and the Implementation Guides on the Washington Publishing Company website (see *Key Contacts*).

MEPS is available through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form;* see *Payment and the RA* within this chapter). After this form has been processed, you will receive a password. Entry into the system requires a valid provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

RAs are available from MEPS in PDF and a flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the "SOR Download" page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks. For more information on MEPS, see *Payment and the RA* later in this chapter.

Paper RA

The paper RA is divided into the following sections: RA notice, paid claims, denied claims, pending claims, credit balance claims, gross adjustments, and reason and remark codes and descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.

Electronic RAs are available for only six weeks on MEPS.

If a claim was denied, read the reason and remark code description before taking any action on the claim.

The pending claims section of the paper RA is informational only. Do not take any action on claims shown here.

Sections of the Paper RA

Section	Description
RA notice	The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.
Paid claims	This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter).
Denied claims	This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter.
Pending claims	All claims that have not reached final disposition will appear in this area of the paper RA (pended claims are not available on X12N 835 transactions). The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied. Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.
Credit balance claims	Credit balance claims are shown here until the credit has been satisfied.
Gross adjustments	Any gross adjustments performed during the previous cycle are shown here.
Reason and remark code description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Sample Paper Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

(1)

HOME IV SERVICES
P.O. BOX 999
ANYTOWN MT 59999

(2) PROVIDER# 0001234567 (3) REMIT ADVICE #123456 (4) WARRANT # 123456 (5) DATE:04/01/04 PAGE 2 (6)

RECIP ID (7)	NAME (8)	SERVICE DATES FROM	TO (10)	UNIT OF SVC (11)	PROCEDURE REVENUE NDC (12)	TOTAL CHARGES (13)	ALLOWED (14)	CO-PAY (15)	REASON/ REMARK CODES (16)
PAID CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	030104	030504	1	S9327	115.00	105.00		
(9) ICN	00409211123000700								
	LESS COPAY DEDUCTION***						5.00 (17)		
	CLAIM TOTAL*******					115.00	100.00		
DENIED CLAIMS - MISCELLANEOUS CLAIMS									
123456790	DOE, JOE EDWARD	030104	030504	1	S9330	150.00	0.00		M68
ICN	00409211123000800			(16)					
PENDING CLAIMS - MISCELLANEOUS CLAIMS									
123456791	DOE, JANE EDWINA	030104	030504	5	S9351	625.00	625.00		MA61
ICN	00409211123000900								

**********THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE**********

MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

M68 MISSING/INCOMPLETE/INVALID ATTENDING OR REFERRING PHYSICIAN IDENTIFICATION.

Key to the Paper RA

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The 7-digit number assigned to the provider when applying for Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. Internal control number (ICN)	Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information: 0 00111 11 123 000123 A B C D E A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or POS pharmacy claim) B = Julian date (e.g. April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)
10. Service dates	Date(s) services were provided. If service(s) were performed in a single day; the same date will appear in both columns
11. Unit of service	The number of services rendered under this procedure or NDC code.
12. Procedure/revenue/NDC	The procedure, revenue, HCPCS, or NDC billed will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount a provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Co-pay	A "Y" indicates cost sharing was deducted, and an "N" indicates cost sharing was not deducted from the payment.
16. Reason/Remark Code	A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, Billed Amount, and Paid Amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Credit balance claims

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

Credit balances can be resolved in two ways:

- By "working off" the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
- By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

The Credit Balance section is informational only. Do not post from credit balance statements.

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

- Providers may resubmit, modify, or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- The time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check, or request Provider Relations to complete a gross adjustment.

Medicaid does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter.)

Rebilling Medicaid

Rebilling is when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* chapter in this manual.

When to rebill Medicaid

- ***Claim Denied.*** Providers may rebill Medicaid when a claim is denied. Check the reason and remark codes, make the appropriate corrections and resubmit the claim (do not use the adjustment form).

Rebill denied claims only after appropriate corrections have been made.

- ***Line Denied.*** When an individual line is denied on a multiple-line claim, correct any errors and submit only the denied line to Medicaid. For CMS-1500 claims, do not use an adjustment form.
- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit the claim.

How to rebill

- Check any reason and remark code listed and make corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to line out or omit all lines that have already been paid.
- Submit insurance information with the corrected claim.

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see *Claim Inquiries* in the *Submitting a Claim* chapter of this manual). Once an incorrect payment has been verified, the provider should submit an *Individual Adjustment Request* form (in *Appendix A*), to Provider Relations. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit over will be a 2, indicating an adjustment. See the *Key to the Paper RA* earlier in this chapter. Adjustments are processed in the same time frame as claims.

When to request an adjustment

- Request an adjustment when the claim was overpaid or underpaid.
- Request an adjustment when the claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).

How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in *Appendix A*. The requirements for adjusting a claim are as follows:

- Adjustments can only be submitted on paid claims; denied claims cannot be adjusted.
- Claims Processing must receive individual claim adjustments within 12 months from the date of service (see *Timely Filing* in the *Billing Procedures* chapter of this manual). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section.

Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A*, or download it from the Provider Information website. Complete *Section A* first with provider and client information and the claim's ICN number (see following table).
2. Complete *Section B* with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
    - Enter the date of service or the line number in the *Date of Service or Line Number* column.
    - Enter the information from the claim form that was incorrect in the *Information on Statement* column.
    - Enter the correct information in the column labeled *Corrected Information*.
3. Attach copies of the RA and a corrected claim if necessary.
    - If the original claim was billed electronically, a copy of the RA will suffice.
    - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider Name and Address	Provider's name and address (and mailing address if different).
2. Recipient Name	The client's name is here.
3.* Internal Control Number (ICN)	There can be only one ICN per Adjustment Request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4.* Provider number	The provider's Medicaid ID number.
5.* Recipient Medicaid Number	Client's Medicaid ID number.
6. Date of Payment	Date claim was paid found on Remittance Advice Field #5 (see the sample RA earlier in this chapter).
7. Amount of Payment	The amount of payment from the Remittance Advice Field #17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of Service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure Code/ N.D.C/ Revenue Code	If the procedure code, NDC, or revenue code are incorrect, complete this line.
3. Dates of Service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed Amount	If the billed amount is incorrect, complete this line.
5. Personal Resource (Nursing Home)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance Credit Amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare Paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount TPL or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount from the provider. This can be done in two ways, by the provider issuing a check to the Department, or by maintaining a credit balance until it has been satisfied with future claims (see *Credit Balance* in this chapter).
- Any questions regarding claims or adjustments should be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section), the monthly *Claim Jumper* newsletter, or provider notice. Mass adjustment claims shown on the RA have an ICN that begins with a "4" (see *Key Fields on the Remittance Advice* earlier in this chapter).

Payment and The RA

Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A). One form must be completed for each provider number. See the following table, *Required Forms for EFT and/or Electronic RA*.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. For questions or changes regarding EFT, contact the Technical Services Center and ask for the Medicaid Direct Deposit Manager (see *Key Contacts*).

Required Forms For EFT and/or Electronic RA

All three forms are required for a provider to receive weekly payment

Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows provider to receive electronic remittance advices on MEPS (must also include MEPS Access Request form)	• Provider Information website • Provider Relations (see *Key Contacts*)	Provider Relations (see *Key Contacts*)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	• Provider Information website (see *Key Contacts*) • Provider's bank	Provider Relations (see *Key Contacts*)
MEPS Access Request Form	Allows provider to receive a password to access their RA on MEPS	• Provider Information website • Virtual Human Services Pavilion • Direct Deposit Manager of the DPHHS Technical Services Center (see *Key Contacts)*	DPHHS address on the form

How Payment Is Calculated

Overview

Though providers do not need the information in this chapter in order to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims. These examples are for April, 2004 and these rates may not apply at other times.

How Cost Sharing is Calculated on Medicaid Claims

Client cost sharing for home infusion therapy services is $5.00 per visit (see the *Billing Procedures* chapter, *Client Cost Sharing*). The client's cost sharing amount is shown on the remittance advice and deducted from the Medicaid allowed amount (see the *Remittance Advices and Adjustments* chapter in this manual). For example, a home infusion therapy provider visits a client and provides one unit of TPN therapy (S9365) every day for fifteen days. This services is billed as 15 units during a 15-day span, and one $5.00 cost sharing fee will be deducted.

Many Medicaid payment methods are based on Medicare, but there are differences. In these cases, the Medicaid method prevails.

How Payment is Calculated on TPL Claims

When a client has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability or TPL. In these cases, the other insurance is the primary payer (as described in the C*oordination of Benefits* chapter of this manual), and Medicaid makes a payment as the secondary payer. For example, a client receives 30 units of antiemetic therapy (S9351) and 30 days of pain management therapy (S9327) during a thirty day period. The third party insurance is billed first and pays $5,000.00. The Medicaid allowed amount for these services totals $6,900.00. The amount the insurance paid ($5,000.00) is subtracted from the Medicaid allowed amount ($6,900.00), leaving a balance of $1,900.00, which Medicaid will pay on this claim.

How Payment is Calculated on Medicare Crossover Claims

When a client has coverage from both Medicaid and Medicare, Medicare is the primary payer as described in the *Coordination of Benefits* chapter of this manual. Medicaid then makes a payment as the secondary payer. For the provider types covered in this manual, Medicaid's payment is calculated so that the total payment to the provider is either the Medicaid allowed amount less the Medicare paid amount or the sum of the Medicare coinsurance and deductible, whichever is lower. This method is sometimes called "lower of" pricing.

Other Factors That May Affect Payment

When Medicaid payment differs from the fee schedule, consider the following:

- The Department pays the lower of the established Medicaid fee or the provider's charge
- Modifiers SH and SJ reduce payment on multiple concurrent therapies
- The client may have an incurment amount that must be met before Medicaid will pay for services (see the *General Information For Providers* manual, *Client Eligibility and Responsibilities* chapter, *Coverage for the Medically Needy* section.
- Date of service; fees for services may change over time.
- Cost sharing, Medicare, and/or TPL payments, which are shown on the remittance advice.

Appendix A

- ***Request for Prescription Drug Prior Authorization***
- ***Paperwork Attachment Cover Sheet***
- ***Montana Medicaid Claim Inquiry Form***
- ***Montana Medicaid Individual Adjustment Request***

Mountain-Pacific Quality Health Foundation

Request for Medicaid Home Infusion Therapy Authorization

Submitter:

Please Type or Print

PATIENT NAME:(Last) (First) (MI)			PATIENT MEDICAID ID NUMBER	PATIENT DATE OF BIRTH
PHYSICIAN #	PHYSICIAN PHONE #	PHYSICIAN FAX #	MAIL, FAX or PHONE COMPLETED FORM TO:	
PHYSICIAN NAME			DRUG PRIOR AUTHORIZATION UNIT Mountain-Pacific Quality Health Foundation 3404 Cooney Drive HELENA, MT 59602 (406)443-6002 or 1-800-395-7961 (PHONE) (406)443-7014 or 1-800-294-1350 (FAX)	
PHYSICIAN STREET ADDRESS				
PHYSICIAN CITY ST ZIP				

HIT #	HIT NAME	HIT PHONE #	HIT FAX #
HIT STREET ADDRESS	HIT CITY	ST	ZIP

SERVICES TO BE AUTHORIZED

	From	Thru	Procedure	Days	Therapy
1.					
2.					
3.					
4.					
5.					

DIAGNOSIS OR CONDITION TREATED BY THIS THERAPY

LEAVE BLANK - PA UNIT USE ONLY

REASON FOR DENIAL OF THERAPY PRIOR AUTHORIZATION

IMPORTANT NOTE: In evaluating requests for prior authorization, the consultant will consider the therapy from the standpoint of published criteria only. If the approval of the request is granted, this does not indicate that the recipient contines to be eligible for Medicaid. It is the responsibility of the provider of service to establish by inspection of the recipient's Medicaid eligibility card and if necessary, by contact with Consultec to determine if the recipient continues to be eligible for Medicaid.

CURRENT RECIPIENT ELIGIBILITY MAY BE VERIFIED BY CALLING CONSULTEC AT 1-800-624-3958 or 406-442-1837

Approval / Denial Status	APPROVE/DENY CODE	THERAPEUTIC CLASS	AUTH. ID	DATE OF REQUEST	PRIOR AUTHORIZATION NUMBER
	0				

MONTANA
Department of Public Health & Human Services

Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number: _____

Date of service: _____

Medicaid provider number: _____

Medicaid client ID number: _____

Type of attachment: _____

Instructions:

This form is used as a cover sheet for attachments to electronic claims sent to Montana Medicaid. The *Paperwork Attachment Control Number* must be the same number as the *Attachment Control Number* on the corresponding electronic claim. This number should consist of the provider's Medicaid ID number, the client's Medicaid ID number and the date of service (mmddyyyy), each separated by a dash (9999999-999999999-99999999). This form may be copied or downloaded from our website www.mtmedicaid.org. If you have questions about which paper attachments are necessary for a claim to process, please call Provider Relations at (406) 442-1837 or (800) 624-3958.

Montana Medicaid Claim Inquiry Form

Provider Name _____
Contact Person _____
Address _____
Date _____
Phone Number _____
Fax Number _____

For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____
Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____
Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____

Mail to: Provider Relations
P.O. Box 8000
Helena, MT 59604

Fax to: (406) 442-4402

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS

_____
Name

_____
Street or P.O. Box

_____
City **State** **Zip**

2. CLIENT NAME

_____

3. INTERNAL CONTROL NUMBER (ICN)

_____

4. PROVIDER NUMBER

_____

5. CLIENT ID NUMBER

_____

6. DATE OF PAYMENT _____

7. AMOUNT OF PAYMENT $ _____

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

270/271 Transactions
The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions
The ASC X12N claim status request (276) and response (277) transactions.

278 Transactions
The ASC X12N request for services review and response used for prior authorization.

835 Transactions
The ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions
The ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)
The ANSI-accredited standards development organization, and one of the six Designated Standards Maintenance Organizations (DSMO), that has created and is tasked to maintain the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

Adjustment
When a claim has been incorrectly paid, the payment amount can be changed by submitting an adjustment request.

Administrative Review
Administrative reviews are the Department's effort to resolve a grievance about a Department decision in order to avoid a hearing. The review includes an informal conference with the Department to review facts, legal authority, and circumstances involved in the adverse action by the Department.

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

Assignment of Benefits
When a provider accepts the maximum allowable charge offered for a given procedure by the insurance company, it is said that the provider accepts assignment.

Audit
A formal or periodic verification of accounts.

Authorization
An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid
Clients with Basic Medicaid have limited Medicaid services. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Bolus
A small volume of drug, which is administered directly into the vein, usually over a time period of 3-5 minutes.

Carrier
A private insurance company.

Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid program. Formerly the Health Care Financing Administration (HCFA).

Children's Health Insurance Plan (CHIP)
CHIP offers low-cost or free health insurance for low-income children younger than 19. Children must be uninsured US citizens or qualified aliens, Montana residents who are not eligible for Medicaid. DPHHS administers the program and purchases health insurance from BlueCross BlueShield (BCBS) of Montana. Benefits for dental services and eyeglasses are provided by DPHHS through the same contractor (ACS) that handles Medicaid provider relations and claims processing.

Claims Attachment
Supplemental information about the services provided to a client that supports medical or other evaluation for payment, post-payment review, or quality control requirements that are directly related to one or more specific services billed on the claim.

Claims Clearinghouse
When a provider contracts with a clearinghouse, the clearinghouse supplies the provider with software that electronically transmits claims to the clearinghouse. The clearinghouse then transmits the claims to the appropriate payers.

Clean Claim
A claim that can be processed without additional information or documentation from or action by the provider of the service.

Client
An individual enrolled in a Department medical assistance program.

Coinsurance
The client's financial responsibility for a medical bill as assigned by Medicare. Medicare coinsurance is usually 20% of the Medicare allowed amount.

Companion Guide
A document provided by some health plans to supplement or clarify information about HIPAA standard transactions (available on the ACS EDI Gateway website).

Continuous
A controlled method of prolonged drug administration that includes the ability to control the delivery rate. This system permits the drug to be available to the body at a constant level.

Copayment
The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic
Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost sharing
The client's financial responsibility for a medical bill, usually in the form of a flat fee.

CPT-4
Physicians' ***Current Procedural Terminology, Fourth Edition***. This book contains procedure codes which are used by medical practitioners in billing for services rendered. The book is published by the American Medical Association.

Credit Balance Claims
Adjusted claims that reduce original payments, causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the remittance advice until the credit has been satisfied.

Crossovers
Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Early & Periodic Screening, Diagnosis & Treatment (EPSDT) Program
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Electronic Data Interchange (EDI)
The communication of information in a stream of data from one party's computer system to another party's computer system.

Electronic Funds Transfer (EFT)
Payment of medical claims that are deposited directly to the provider's bank account.

Emergency Services
Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

Explanation of Benefits Codes (EOB)
A three digit code which prints on Medicaid remittance advice (RA) that explains why a claim was denied or suspended. The explanation of the EOB codes is found at the end of the RA.

Explanation of Medicare Benefits (EOMB)
A notice sent to providers informing them of the services which have been paid by Medicare.

Fair Hearing
Providers may request a fair hearing when the provider believes the Department's administrative review determination fails to comply with applicable laws, regulations, rules or policies. Fair hearings include a hearings officer, attorneys, and witnesses for both parties.

Fiscal Agent
ACS is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.85 et seq.

Full Medicaid
Clients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Gross Adjustment
These adjustments are done in a lump-sum payment or reduction without regard to individual claims.

HCPCS
Acronym for the Healthcare Common Procedure Coding System, and is pronounced "hick-picks." There are three types of HCPCS codes:

- Level 1 includes the CPT-4 codes.
- Level 2 includes the alphanumeric codes A - V which CMS maintains for a wide range of services from ambulance trips to hearing aids which are not addressed by CPT-4 coding.
- Level 3 includes the alphanumeric codes W - Z which are assigned for use by state agencies (also known as local codes).

Health Insurance Portability and Accountability Act (HIPAA)
A federal plan designed to improve efficiency of the health care system by establishing standards for transmission, storage, and handling of data.

ICD-9-CM
The International Classification of Diseases, 9th Revision, Clinical Modification. This is a three volume set of books which contains the diagnosis codes used in coding claims, as well as the procedure codes used in billing for services performed in a hospital setting.

Implementation Guide (IG)
The official source of specifications with respect to how the HIPAA administrative and financial transactions are to be implemented (available on the Washington Publishing Company website).

Indian Health Services (IHS)
IHS provides federal health services to American Indians and Alaska Natives.

Infusion
A parenteral solution administered intravenously or subcutaneously over an extended period of time. Typically requires an infusion pump, but may be accomplished by gravity feed.

Infusion Device/Infusion Pump
Electronic or mechanical device designed to provide continuous, intermittent, circadian, cyclical and/or bolus delivery of medications or nutrients via parenteral. Infusion pumps are generally considered to be closed systems, which helps to prevent inadvertent contact with sterile solutions. Infusion devices may be disposable or reusable. All are covered within the per diem.

Internal Control Number (ICN)
The unique number assigned to each claim transaction that is used for tracking.

Intravenous (IV)
Injection of a solution directly into the vein, usually the cephalic or median basilica vein of the arm.

Mass Adjustment
Adjustments made to multiple claims at the same time. They generally occur when the Department has a change of policy or fees that is retroactive, or when a system error that affected claims processing is identified.

Medicaid
A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medically Necessary
A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare
The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)
This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

National Drug Code (NDC)
An 11-digit number the manufacturer assigns to a pharmaceutical product and attaches to the product container at the time of packaging that identifies the product's manufacturer, dose form and strength, and package size.

Parenteral
Denoting any medication route other than the alimentary canal, such as intravenous, subcutaneous, intramuscular, or mucosal.

PASSPORT Authorization Number
This number is either the PASSPORT provider's PASSPORT number or Medicaid provider ID. When a PASSPORT provider refers a client to another provider for services, this number is given to the other provider and is required when processing the claim.

PASSPORT To Health
A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Pay and Chase
Medicaid pays a claim and then recovers payment from the third party carrier that is financially responsible for all or part of the claim.

Pending Claim
These claims have been entered into the system, but have not reached final disposition. They require either additional review or are waiting for client eligibility information.

Potential Third Party Liability
Any entity that may be liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Prior Authorization (PA)
The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Provider or Provider of Service
An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

Rebilling
When a provider submits a claim that was previously submitted for payment but was either returned or denied.

Referral
When providers refer clients to other Medicaid providers for medically necessary services that they cannot provide.

Remittance Advice (RA)
Provides details of all transactions that have occurred during the previous two weeks, includes paid, denied, and pending claims.

Remittance Advice Notice
The first page of the remittance advice that contains important messages for providers.

Restricted Card
When utilization of services is excessive, inappropriate, or fraudulent, a client is restricted to designated providers.

Retroactive Eligibility
When a client is determined to be eligible for Medicaid effective prior to the current date.

Subcutaneous
Infusion of solutions into the subcutaneous tissue beneath the skin.

Third Party Liability (TPL)
Any entity that is liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Usual and Customary
The fee that the provider most frequently charges the general public for a service or item.

Virtual Human Services Pavilion (VHSP)
This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor's Office, and Montana. http://vhsp.dphhs.state.mt.us

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